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The Voice for Health Care Consumers

SPECIAL REPORT

May 2001

Medicaid Managed Care Consumer Protection Regulations: No Patients' Rights for the Poor?

A teenager who lives in Maryland had to wait six months to have a bullet removed from his chest because his Medicaid HMO had too few specialists.[1]

INTRODUCTION

Millions of low-income Americans stand to lose vital health care consumer protections if the Bush Administration refuses to implement—or significantly weakens—pending Medicaid managed care regulations. The regulations implement provisions of the Balanced Budget Act of 1997 (BBA), which included the most sweeping changes to Medicaid since the program was created 36 years ago. In essence, the BBA gave states the ability—without first having to obtain federal approval—to require Medicaid beneficiaries to enroll in managed care plans. In exchange, beneficiaries were given substantial new consumer protections. The consumer protection provisions were, in effect, a *quid pro quo* for the additional flexibility granted to the states in how they could administer their Medicaid programs. As 41 Members of Congress observed in a letter to Health and Human Services Secretary Tommy Thompson, "Congress struck a careful balance by matching new flexibility with meaningful patient protections."[2] Now this "careful balance" is being threatened as the Administration delays action on the regulations.

Regulations Delayed and May Be Weakened

Final regulations implementing the consumer protections enacted in the BBA were issued by the Health Care Financing Administration (HCFA) in January 2001. The new beneficiary protections were scheduled to take effect on April 19, 2001. Now, however, the Bush Administration has postponed the effective date of the regulations for at least 60 days and is considering re-opening them to make changes that were already considered and rejected by HCFA. Should the Administration decide to change the regulations, the delay—and, potentially, the substance of changes to be made —could harm Medicaid beneficiaries, who are at risk of being denied information, rights, and access to quality health care services and who therefore need the protections of the pending regulations.

Why Regulations Are Needed

In recent years, states have acted aggressively to move Medicaid beneficiaries into managed care. In 2000, nearly 19 million Medicaid beneficiaries were enrolled in managed care (see Table 1). While managed care has the potential to save money for the states and improve coordination of care, the change can also be disruptive and even harmful to beneficiaries. Medicaid beneficiaries have low incomes and are

Table 1

Medicaid Managed Care Enrollment as of June 30, 2000

State	Enrollment	State	Enrollment
ALABAMA	325,059	NEBRASKA	140,199
ALASKA	0	NEVADA	37,945
ARIZONA	442,254	NEW HAMPSHIRE	4,432
ARKANSAS	222,261	NEW JERSEY	371,641
CALIFORNIA	2,525,406	NEW MEXICO	199,297
COLORADO	254,232	NEW YORK	691,422
CONNECTICUT	229,995	NORTH CAROLINA	598,852
DELAWARE	75,535	NORTH DAKOTA	23,962
DISTRICT OF COLUMBIA	78,864	OHIO	239,460
FLORIDA	1,016,641	OKLAHOMA	279,205
GEORGIA	806,009	OREGON	312,064
HAWAII	121,581	PENNSYLVANIA	975,211
IDAHO	32,338	PUERTO RICO	828,021
ILLINOIS	137,622	RHODE ISLAND	104,041
INDIANA	376,066	SOUTH CAROLINA	32,149
IOWA	182,251	SOUTH DAKOTA	67,835
KANSAS	108,093	TENNESSEE	1,323,319
KENTUCKY	464,191	TEXAS	606,238
LOUISIANA	48,802	UTAH	119,200
MAINE	57,151	VERMONT	55,605
MARYLAND	385,687	VIRGINIA	280,978
MASSACHUSETTS	583,324	WASHINGTON	800,481
MICHIGAN	1,063,557	WEST VIRGINIA	90,631
MINNESOTA	291,365	WISCONSIN	210,423
MISSISSIPPI	218,431	WYOMING	0
MISSOURI	304,499		
MONTANA	42,312	**TOTAL**	**18,786,137**

Source: Medicare Managed Care Enrollment Report, available at (www.hcfa.gov/medicaid/mcsten00.htm).

vulnerable to being medically underserved. As the General Accounting Office noted, "managed care . . . can create an incentive to underserve or even deny beneficiaries access to needed care since plans and, in some cases, providers can profit from not delivering services. Moreover, Medicaid beneficiaries required to enroll in managed care may find it difficult or impossible to seek alternative care if they find that plan providers fail to meet their needs."[3]

Medicaid is our nation's primary health care safety net for people with disabilities. In a November 2000 study mandated by the BBA, HCFA found that additional safeguards are needed to protect people with disabilities, the homeless, and those with other special health care needs. In particular, the report raised concerns about ensuring access to experienced providers and improving monitoring of the quality of care provided.

Over the past decade, as reliance on managed care arrangements has grown, advocates have documented an extensive record of harm to beneficiaries when the federal government did not aggressively monitor state activities. Although states and health plans have argued that these problems were simply

"outliers"—rare incidents that did not reflect the care received by most beneficiaries—the record of abuses from across the country is extensive, longstanding, and troublesome. Therefore, strong systems must be in place to protect all beneficiaries—and to quickly remedy inevitable lapses in the delivery of quality health care.

Finally, regulations are needed to protect the considerable public investment in Medicaid. In 1999, total spending for the Medicaid program was $180.9 billion; the federal government contributed $102.5 billion, or 57 percent of the total cost.[4] The Medicaid managed care consumer protection regulations, while still permitting wide variation among state programs, will help guarantee minimum national standards and ensure that federal funds are being used appropriately.

Regulations Offer Basic, Common-Sense Protections

The new regulations establish standards for managed care programs serving the diverse needs of Medicaid beneficiaries. The regulations, which address specific types of problems already experienced in managed care, include such basic protections as grievance rights; assurances that managed care plans serving Medicaid beneficiaries will have adequate provider networks (with enough primary care providers and specialists); and requirements that beneficiaries be clearly informed about how the new system of health care delivery works. The following discussion highlights a few of the issues addressed by the regulations.

MEDICAID MANAGED CARE: Problem Areas

INFORMATION

Choosing a health plan, picking a doctor, understanding how to obtain referrals to specialists—these are a few of the things consumers must do to receive high quality health care. None of them can be done well without adequate information. Yet states have often failed to ensure that Medicaid beneficiaries had the information they needed—in a form they could understand—to navigate the managed care system. The results of that failure include beneficiaries who are totally confused about where they are supposed to go to get services, different members of the same family being enrolled in different health plans, beneficiaries with limited English capacity who cannot convey the nature of their illness to their physician, and more.

A CLOSER LOOK

Despite long-standing laws requiring that Medicaid beneficiaries receive services in an accessible language, a Medicaid beneficiary who was deaf was unable to obtain physician services with a sign language interpreter until the Office for Civil Rights in the U.S. Department of Health and Human Services intervened.[5]

—District of Columbia

How the Regulations Address These Problems: The regulations require states and managed care organizations (MCOs) to provide beneficiaries with the information they need—and to provide that information in a language they can understand. When states require Medicaid beneficiaries to enroll in managed care, they must make sure beneficiaries receive information about the basic features of managed care, including a clear explanation of who is exempted from the requirement. Once beneficiaries are enrolled in managed care plans, the regulations require that information be provided in the languages commonly spoken by beneficiaries in a particular community, and in alternative formats, such as Braille. Translation services and sign language interpretation services also must be provided free-of-charge.

ACCESS TO SERVICES

To ensure that beneficiaries get the care they need, MCOs must make available a range of qualified providers who are experienced in serving the medical needs of their enrollees. Indeed, one of the potential advantages of managed care for Medicaid beneficiaries is that enrolling in an MCO could guarantee them

access to a full range of providers willing to accept them as patients. Unfortunately, states have contracted with MCOs whose networks have not delivered on their promise to ensure access to an appropriate number of providers, range of specialists, and sufficient providers experienced in treating specific complex conditions. They have also failed to develop adequate mechanisms for allowing enrollees to go out of the network when the MCO is unable to provide access to a type of provider or an experienced provider within the network. This has resulted in long waiting times for appointments, difficulties getting appointments, and an inability to see specialists—or providers with experience treating people with disabilities or other complex health conditions.

A CLOSER LOOK

One teenager had to wait six months to see a specialist in order to have a bullet removed from his chest. This was identified in a study of HealthChoice, Maryland's Medicaid managed care program for children. The study also found that children are experiencing difficulty getting to see pediatric specialists. When called for appointments, many specialists who were listed in MCO directories said that they had never participated in HealthChoice, no longer participated, were not accepting HealthChoice patients, or could not see the child for several months.[6]

—Maryland

A CLOSER LOOK

A foster child with special health care needs was enrolled in a managed care plan. A pediatrician, rather than referring the child to the specialist he needed, diagnosed him with clubbed feet and put him in braces with his shoes connected by a cross bar that he was required to wear 22 hours a day for five months. Eventually, the child was disenrolled from managed care and enrolled in traditional Medicaid where he saw an orthopedic specialist who diagnosed his condition as femoral anteversion. The specialist said that the braces he wore not only were unnecessary, but also may have contributed to the femoral anteversion.[7]

—Indiana

How the Regulations Address These Problems: The regulations require states to ensure that MCOs establish and maintain networks that are adequate to serve Medicaid enrollees. The adequacy of the network must take into account the needs of pregnant women, children, and persons with special health care needs. MCOs must also have policies and procedures in place to deal with instances when enrollees need special expertise not available in the MCO's provider network. The regulations also require MCOs to meet state standards for timely access to care and services, taking into account the urgency of need for services. If an MCO network is unable to provide necessary medical services, the MCO must cover these services out-of-network for the enrollee.

CONTINUITY OF CARE

For people with disabilities and other persons with serious and complex health conditions, interruptions in treatment can be very detrimental. Medicaid is a safety-net health insurance program that serves many of the most medically vulnerable people living in the United States, including roughly 7 million blind and disabled individuals. Unfortunately, some states have moved people with disabilities and other beneficiaries into managed care programs that are not equipped to meet their health care needs. States have also shifted beneficiaries from fee-for-service into managed care without adequate transition planning.

A CLOSER LOOK

A woman with HIV missed several days' worth of medicine because a druggist didn't know how to bill for a prescription. Interruptions or delays in taking the life-saving medicines can lead to drug resistance, which means that the prescribed drugs—or any other available drug—may no longer be effective.[8]

—Pennsylvania

How the Regulations Address These Problems: The regulations require states to have a mechanism for ensuring continued access to services when an enrollee with an on-going health care need is transitioned from fee-for-service Medicaid to an MCO, from one MCO to another, or from an MCO to fee-for-service Medicaid. States are also required to arrange for any Medicaid services to be provided without delay if an MCO's contract is terminated or if an individual is disenrolled from an MCO, unless they were disenrolled because they are no longer eligible for Medicaid

RIGHT TO GRIEVE

Longstanding Medicaid regulations have guaranteed individuals the right to request a state fair hearing (a form of independent review) if they are denied a service or if a previously authorized service is delayed, reduced, or terminated. Existing regulations also require Medicaid MCOs to operate an internal grievance process that is approved by the state, provides for a prompt resolution of the grievance, and ensures that someone with decision-making authority is involved in the process. These existing grievance procedures have not worked as intended, however, because there are many barriers to Medicaid beneficiaries filing grievances: many individuals do not know that they have a right to grieve, many MCO policies are confusing, persons filing a grievance are not guaranteed a resolution within a specific timeframe, and many individuals do not feel that their specific request is fairly considered by the MCO.

A CLOSER LOOK

A Medicaid beneficiary with disabilities was denied a replacement power scooter because her MCO did not consider it to be medically necessary. The MCO did not explain what evidence it used to determine it was not necessary. The beneficiary appealed stating, "The scooter is the legs I do not have. . . . The scooter enables me to get around my apartment." Approximately two months after the initial denial, the MCO completed a paper review and replied, "The Initial Grievance Committee voted to uphold the original denial . . . based on the fact that the medical necessity could not be established. . . . If you choose to pursue this further, you can appeal to the Grievance Review Committee." The Grievance Review Committee affirmed the denial, and at no point informed her of her right to request a state fair hearing. After advocates went to federal court to apply for a temporary restraining order, the MCO agreed to provide the scooter.[9]

—Pennsylvania

A CLOSER LOOK

When Tennessee established TennCare, the statewide Medicaid managed care program, the state required beneficiaries to go through informal complaint procedures before requesting a Medicaid fair hearing. The delay that is caused by requiring individuals to go through a lengthy informal process before having access to an impartial decision-maker led three plaintiffs to sue the state Medicaid program. One individual suffered a stroke while contesting her MCO's denial of specialty care to clear arteries in her neck. The judge ordered the state Medicaid agency to assure the opportunity of hearings, presided over by impartial decision-makers; to continue benefits pending the hearing decision; and to resolve disputes within 90 days of an enrollee's first request for review of a health care decision.[10]

—Tennessee

How the Regulations Address These Problems: The regulations seek to ensure that Medicaid beneficiaries have the same level of grievance protections as enrollees in Medicare MCOs. Specifically, the regulations require MCOs to provide notice whenever they take an action, such as denying, terminating, or reducing a health service. This notice must tell the individual what action the MCO is taking, why, how the individual can appeal the MCO's decision, and how to request a state fair hearing. The regulations also seek to ensure timely resolution by establishing a 30-day standard for most appeals, and an expedited appeal process that requires resolution in 72 hours for medically urgent cases.

QUALITY ASSURANCE

One of the potential advantages of managed care over fee-for-service health care is the capacity for increased accountability on the part of MCOs and providers. Unfortunately, even where protections exist that are intended to ensure that beneficiaries receive high-quality care, MCOs do not always deliver on their promises—and states have not been very effective at holding MCOs accountable for providing high-quality services. This is especially problematic since managed care limits a Medicaid beneficiary's choice of provider. Beneficiaries could be trapped in an MCO where they cannot get the services they need and they have no place to go.

A CLOSER LOOK

California contracted with an independent firm to assess the quality of care provided to Medicaid beneficiaries who were pregnant women or well-children. The firm collected and reviewed medical records from MCOs. Many plans scored poorly on the initial review, but disputed the claim because, when an MCO failed to provide a record, the reviewer recorded this as an individual who did not receive appropriate care. When records were reviewed only counting records that were present (a method that potentially undercounts problems), reviewers still found that only 40 percent of children received the appropriate well-child visits.[11] *—California*

A CLOSER LOOK

External reviews of TennCare Partners, a managed care program for mentally ill Medicaid beneficiaries in Tennessee, showed that the program offered no preventive care and, in many cases, no follow-up care for the mentally ill who were released from hospitals. One of two contractors with the plan was also found to be "grossly out of compliance" with requirements to adopt clinical standards to guide decisions on patient care.[12] *—Tennessee*

How the Regulations Address These Problems: The regulations require states to monitor MCO activities, including enrollment and disenrollment practices, which are often indicators of the quality of care provided. States are also required to establish their own quality assessment and performance improvement strategy that is developed with public input. MCOs are required to meet minimum performance levels on standardized quality assessment measures.

Extensive Public Consultation in Development of Regulations

In developing this final rule, HCFA reviewed 305 public comments responding to its draft rule, which was published in September 1998. Comments were received from beneficiaries and consumer advocacy organizations as well as from states, health plans, providers, and other stakeholders. Following the comment period, pursuant to the Administrative Procedures Act, HCFA catalogued and considered every comment received. After more than two years of fact-finding and deliberation, HCFA issued its final rule on January 19, 2001.

Congress Responded to Competing Interests in Enacting the BBA

In enacting the BBA in 1997, Congress responded to a multitude of interests and forces pushing it to alter the Medicaid program in competing ways. States were aggressively advocating for new flexibility to force all Medicaid beneficiaries to enroll in managed care programs.

Under the pre-1997 Medicaid law, beneficiaries were guaranteed freedom of choice of health care providers. This freedom of choice provision—giving beneficiaries the ability to vote with their feet—was a critical consumer protection. It was also an obstacle to early state attempts to move Medicaid beneficiaries into managed care. One of the key features of managed care is its use of closed networks that limit provider choice in order to save resources and operate more efficiently. To get around this impediment, the Secretary of Health and Human Services (HHS) agreed to waive the freedom of choice provision for individual states that requested such a waiver. When considering waiver requests, HHS negotiated with the states about the terms and conditions that would accompany the waiver. Although consumer advocates have complained that waivers were granted too readily and that the federal review process was too cursory, states viewed the waiver process as being too slow and cumbersome.

The earliest state Medicaid managed care programs were carefully limited to small-scale demonstrations, enrollment of only the healthiest Medicaid beneficiaries (mostly healthy women and children), or voluntary enrollment in managed care. In the mid-1990s, however, states began to move their entire Medicaid populations into managed care programs, or they began to develop mandatory managed care programs that included Medicaid recipients receiving supplemental security income (SSI). SSI recipients are people with disabilities—a Medicaid population with diverse, extensive, and costly health care needs. Mandatory managed care raises concerns for all Medicaid beneficiary populations. Their needs can be different from those of persons with private health insurance, and commercial MCOs are not accustomed to serving Medicaid beneficiaries. The widespread concern that managed care may tend to reduce *appropriate,* as well as inappropriate, use of care is only heightened when the most medically vulnerable Medicaid beneficiaries are affected: SSI-eligible beneficiaries, children and adults with disabilities, and other persons with special health care needs.

While states were advocating against any new federal requirements and consumer advocates were demanding more federal protection, the issues and challenges of serving Medicaid beneficiaries in managed care programs were being documented. A GAO study found that "one of the challenges for [state Medicaid programs] is developing both the service networks and the necessary assurances that the health care needs of disabled beneficiaries are being met appropriately."[13] One of the principal findings of the study was that "significant efforts [are] needed to ensure quality." As a follow-up to this report, the U.S. Senate Special Committee on Aging held a series of forums on Medicaid managed care and implications for the elderly and others with special needs. These forums documented the challenges of serving people with special health care needs in Medicaid managed care.[14]

It was in this context that the Congress enacted the consumer protection and quality assurance provisions of the BBA. Congress deliberately balanced increased state flexibility with the establishment of substantial new consumer protection and quality assurance provisions. The BBA also instructed the Secretary of Health and Human Services to conduct a study of what, if any, safeguards are necessary to protect individuals with special health care needs in Medicaid managed care.

If the Bush Administration responds to a concerted lobbying effort by states and MCOs—to further delay or weaken key consumer protections—then the careful balance that Congress struck will be lost.

APPENDIX I:

WHAT'S IN THE MEDICAID MANAGED CARE FINAL RULE?

The following are major consumer protection and quality assurance provisions of the final rule:[19]

Mandatory Managed Care

- States can mandate managed care enrollment without seeking a waiver for all Medicaid enrollees, except:
  1. dual eligibles (persons who receive both Medicaid and Medicare);
  2. children under 19 with special health care needs; and
  3. Indians (in most circumstances) who are members of federally recognized tribes.
- Except in rural areas and certain county-operated health insuring organizations, Medicaid beneficiaries are guaranteed a choice of at least two health plans. Rural beneficiaries and persons in these county-run organizations must be given a choice of at least two primary care providers.

Information

- States must provide written information in those languages spoken by a significant number or percentage of enrollees or potential enrollees. MCOs are required to make written information available in languages prevalent in their service areas.
- State and MCO materials must be in a format and language that is easily understood and be available in alternative formats.
- States must provide potential enrollees with information about the basic features of managed care, which populations are excluded from enrollment, MCO responsibilities for care coordination, and information specific to each MCO, including which benefits are covered and which providers are part of the MCO network.
- MCOs must provide enrollees a range of information including: the kinds, amount, and duration of benefits provided under the MCO's contract with the state; information about enrollee rights; procedures for obtaining benefits; the names, location, and non-English languages of network providers; MCO policies on referrals to specialists; any cost sharing; grievance and appeal rights; and where and how to obtain Medicaid benefits that are not provided by the MCO.
- MCOs are required to receive state approval before distributing marketing materials, and materials must be distributed to their entire service area.

Access to Services

- MCOs are prohibited from disenrolling beneficiaries on the basis of various factors, including the enrollee's health status or use of medical services.
- Enrollees are given a right to change plans for any reason in the first 90 days after enrollment and at least once every 12 months thereafter. Enrollees can also disenroll, at any time, for cause.

- MCOs must pay for emergency services based on the "prudent layperson" standard.
- States must receive assurances that MCOs maintain an appropriate network and, in developing this network, must consider "the anticipated Medicaid enrollment, with particular attention to pregnant women, children, and persons with special health care needs."
- States are required to identify all beneficiaries at risk of having special health care needs. MCOs must make a best effort to perform an initial screening within 30 days for all enrollees identified by the state. For all persons who are determined to have special health care needs, the screening must be followed by a comprehensive health assessment within an additional 30 days.

Enrollee Rights

- States must ensure that MCO enrollees are guaranteed specific rights. These include an enrollee's right:

  1. To be treated with respect and shown consideration for one's dignity and privacy;
  2. To receive information on available treatment options and alternatives;
  3. To participate in decisions regarding one's own health care, including the right to refuse treatment;
  4. To be free from restraints and seclusion as a means of coercion, discipline, convenience, or retaliation; and
  5. To obtain a second opinion from an appropriate, qualified health care professional.

Grievance Systems

- MCOs must have in place a system that enables enrollees to appeal: denials or limited authorizations of services; reductions, suspensions, or terminations of previously authorized services; or denials of payment for services. For a standard (non-expedited) appeal, the MCO must generally decide the appeal within 30 days.
- Individuals maintain a right to request a state fair hearing. States can require enrollees to go through an appeal before requesting a fair hearing.
- MCOs must have in place a system that enables enrollees to express dissatisfaction with aspects of their care that are not eligible for appeal. This may include situations where enrollees are dissatisfied with the quality of care they receive.
- Enrollees have a right to have grievances and appeals resolved as quickly as their medical conditions require. Enrollees (or their provider) also must be given an opportunity to request an expedited resolution of grievances and appeals when taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.
- For previously authorized services, enrollees can request continued benefits pending the resolution of an appeal. As with fee-for-service Medicaid, if the appeal is ultimately decided against the enrollee, the enrollee can be held liable for the cost of those services.

Quality Assurance

- States are required to monitor MCO activities, including, at a minimum: enrollment and disenrollment operations, processing of grievances and appeals, and violations of the law.
- States are required to develop procedures for educating MCOs on the clinical and other needs of enrollees with special health care needs.
- States are required to have a written quality assessment and performance improvement strategy that was developed with input from beneficiaries and stakeholders and that is published for public comment before being finalized.
- States must establish procedures for identifying the race, ethnicity, and primary language spoken by each enrollee. The state must provide this information to the MCO at the time of enrollment.
- MCOs are required to achieve minimum performance levels on standardized quality assessment measures and conduct performance improvement projects each year related to specific clinical and non-clinical areas.

Adequate Payments

- HCFA policy that limited managed care capitated payments to a fee-for-service upper payment limit is eliminated.
- A new proposed rule requires that capitated payments be actuarially sound and appropriate for the populations covered and the range of services to be furnished.

Sanctions

- States are required to establish in their contracts with MCOs the ability to impose intermediate sanctions in circumstances when an MCO: fails to provide medically necessary services; imposes premiums or charges on enrollees that are in excess of those permitted under the Medicaid program; discriminates among enrollees on the basis of health status or need for health care services; or misrepresents or falsifies information.
- States are empowered to impose the following types of penalties: civil money penalties; appointment of temporary management of the MCO; granting to enrollees the right to terminate enrollment; suspension of new enrollment; and suspension of payment.
- States are empowered to terminate MCO contracts if an MCO has failed to substantively meet the terms of its contract.

Endnotes

[1] *On the Front-Line: What Parents and Pediatric Practices Say About Maryland's Healthcare System for Low- and Moderate-Income Children*, Advocates for Children and Youth, 2000.

[2] Dingell, John et al., letter to the Tommy G. Thompson, Secretary, Department of Health and Human Services, March 29, 2001.

[3] GAO, *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort*, GAO-HEHS-97-86 (Washington: U.S. General Accounting Office, May 1997).

[4] Health Care Financing Administration, *Medicaid: A Brief Summary* (www.hcfa.gov/pubforms/actuary/ormedmed/default4.htm).

[5] *OCR Update* (Washington: U.S. Department of Health and Human Services, Office for Civil Rights, 1999).

[6] *On the Front-Line,* op. cit.

[7] Personal communication with parent of Medicaid beneficiary.

[8] "Critics Say State's Medicaid Prescription Program Works Poorly," *Philadelphia Inquirer*, February 15, 1999.

[9] Source: *Jamie Sheller, attorney, Sheller, Ludwig, and Badey,* Philadelphia, PA, 1997.

[10] *Daniels v. Wadley*, *926 F. Supp. 1305* (1996).

[11] Medi-Cal Community Assistance Project, *Is Quality Really Being Measured in Medi-Cal Managed Care?* (Washington: Families USA, July 1999).

[12] Paula Wade, "TennCare Failing Mentally Ill," *The Commercial Appeal,* Memphis, TN, 1998.

[13] GAO, *Medicaid Managed Care: Serving the Disabled Challenges State Programs*, GAO-HEHS-96-136 (Washington: U.S. General Accounting Office, July 1996).

[14] *Medicaid Managed Care: The Elderly and Others with Special Needs*, Forums before the Special Committee on Aging, U.S. Senate, 1997 (Serial No. 105-9).

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